No. 49516-3

COURT OF APPEALS
DIVISION II
OF THE STATE OF WASHINGTON

Lisa Barton, an individual,

Appellant,

v.

Dr. Steven Sandifer, D.C. and Jane Doe Sandifer, individually and their marital community, and Champion Chiropractic Center, INC., a Washington Corporation,

Respondents.

APPELLANT'S BRIEF

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Plm 12/22

TABLE OF CONTENTS

Page Number

TABLE OF AUTHORITIES

STATUTES — Page Number

CASES — Page Number

COURT RULES — Page Number

TREATIES — Page Number

INTRODUCTION

The undisputed record on appeal of this case is that the Defendant "very specifically admitted" to the Plaintiff that his chiropractic treatment---manipulation of her neck---had caused her to suffer a stroke, for which he "apologized profusely". Further, the undisputed record on appeal is that the Defendant likewise "very specifically agreed" that he was "responsible for the harm he had caused [Plaintiff]", going on to tell her that "this exact situation" is why "he carries insurance", and that her would "contact his insurance company as soon as possible".

Plaintiff filed suit. A few months thereafter, still over a year from trial, and not quite five months from the deadline for designating experts, Defendant moved for Summary Judgment, claiming that Plaintiff had no "competent expert testimony" in support of her case. Neither Defendant's Motion nor his Reply contained "competent expert testimony" on any issue; likewise, neither the Motion nor the Reply explained or denied Plaintiff's undisputed declaration setting forth the above facts. The Motion and Reply included and advanced arguments based upon opinions contained in unauthenticated medical records, but was unaccompanied by any "competent expert testimony" interpreting the records themselves, let alone validating the opinions they contained.

The Trial Court granted the Motion, effectively advancing the deadline for designating experts some five months, and this in the face of undisputed evidence that the Defendant himself had admitted liability and causation directly to the Plaintiff.

ASSIGNMENTS OF ERROR

Assignment of Error 1. The Trial Court erred in granting Summary Judgment dismissing Plaintiff's negligence claim---months before the deadline for disclosing expert witnesses---in the face of undisputed evidence that the Defendant had admitted directly to the Plaintiff that his treatment had caused her stroke, that he had "apologized profusely" so injuring her, that this "exact situation" was why he carried insurance, and that he would "contact his insurance company as soon as possible".

Issue: Does the above evidence create a genuine issue of fact on the issues of negligence and causation?

Assignment of Error 2. The Trial Court erred in granting Summary Judgment dismissing Plaintiff's informed consent claim in the face of the above evidence, and in the face of (1) undisputed evidence that Defendant's own "informed consent" document specifically refers to the risk of stroke from his treatment, and (2) undisputed evidence that Plaintiff had "no memory" of signing the document, and no one went over its contents with her.

Issue: Does the above evidence create a genuine issue on the "materiality" of the risk of stroke from the treatment Plaintiff received, and whether her signature on the consent form constitutes a complete defense under RCW 7.70.060?

STATEMENT OF THE CASE

1. Plaintiff Lisa Barton ("Lisa") suffered a serious stroke two days after her second chiropractic manipulation performed by the Defendant Steven Sandifer, D.C. ("Dr. Sandifer"). (CP 75-79, Exhibit 9 to Declaration of Amanda Daylong, CP 13-49).

2. In her Declaration (CP 75-79), Lisa described events as follows:

> "In July of 2014, I gave a friend a ride to an appointment with the Defendant Steven Sandifer, a chiropractor. Because I had been having minor neck/back pain occasionally, and because my friend seemed to like Dr. Sandifer, I decided to seek treatment with him.
>
> My first meeting with Dr. Sandifer was July 14th, 2014. There was no treatment that day. He spoke of a 'plan' for my treatment, which he described as a "process".

3. Lisa's Declaration (CP 75-79) describes the "informed consent" process, such as it was:

> "I have now seen the "informed consent" document included with the Defendant's Motion for Summary Judgment, which I signed that day. I have no memory of having signed the document and nobody went over its contents with me. In fact, if the risks it refers to---including "fractures, disc injuries, stroke, dislocations, sprains/strains, physiotherapy burns"---had been explained to me, I wouldn't have gone through with the treatment.

4. The consent form (Ex. 6 to Declaration of Amanda Daylong, CP 13-49) does acknowledge "stroke" as a "risk of treatment".

5. Lisa's actual treatment commenced the next visit (CP 75-79):

> "The first actual treatment was July 16th, 2014. During that first session, Dr. Sandifer twisted my neck and there was a "pop" and immediate, severe pain. I screamed and began crying. He said something like "I know, the sound can be scary", and I replied "No, it hurts!" Dr. Sandifer showed no concern whatsoever, and I assume that the pain I felt was part of the "process" of treatment.

6. Lisa went back in another week (Id):

> "I went back for my second session a week or so later, and Dr. Sandifer performed the same "twisting" motion on my neck. Again, Dr. Sandifer expressed no concern and I continued to believe that the pain I felt was a necessary part of the "process" of my treatment.

7. Disaster followed the second treatment (Id):

> "Two days after that second visit I suffered a stroke, for which I was hospitalized several days, and from which I am still struggling to recover".

8. Upon her release from the hospital, and again several months later, Lisa had conversations with Dr. Sandifer. Due to the importance of her testimony as to these conversations, her Declaration will be quoted at length (CP 75-79):

> "Within days of my release from the hospital, Dr. Sandifer called me at home. He knew of the stroke and was sympathetic, but began asking me questions, obviously trying to identify some cause for it other than his manipulations. He specifically asked if I were on birth control pills, saying that they can occasionally cause strokes. I was not on birth control pills and told him so, but I was not at all comfortable with the conversation and ended the conversation.
>
> In January of 2015, I had another conversation with Dr. Sandifer. I told him of how drastically the stroke had impacted my life, and he apologized profusely. He told me that he had "not been able to sleep for a month" after my stroke **because he was so upset at having caused it**. He told me that nothing like this had ever happened to him in his career, or to his father in his own chiropractic e career.
>
> "During this conversation, I very specifically told Dr. Sandifer that I would like some sort of acknowledgment from him that his treatment had caused my stroke. Dr. Sandifer very specifically agreed that his treatment had caused my stroke. He told me that "this exact situation" is why he carries insurance, and that he would contact his insurance company as soon as possible". (all emphasis in original)

9. Lisa retained counsel and in February, 2016, suit was filed. (CP 4-5). The Case Schedule set trial for August 14th, 2017, and the deadline for disclosing expert witnesses was January 17, 2017. (CP 10)

10. On August 5th, 2016, Defendant moved for Summary Judgment. (CP 50-64). Due to scheduling conflicts, the Motion was continued until September 30th, 2016.

11. The Motion was accompanied by no Declaration or testimony from Dr.Sandifer, or from any other witness, expert or otherwise. (CP 50-64) It quoted from unauthenticated medical records of Lisa's care but there was no expert testimony actually interpreting the records for the Court. The Motion was based upon the supposed "lack of competent testimony" supporting Plaintiff's claims of negligence and failure to obtain informed consent.

12. Lisa responded with her Declaration, and by pointing out that not only was trial about a year away, the deadline for identifying experts was still months away, even after the continuance. (CP 75-79, CP 80-90).

13. The Court granted the Motion and this appeal followed. (CP 201, 102; CP103-106).

ARGUMENT

The Defendant's own words should have defeated Summary Judgment. They are obvious "admissions" under ER 801 (d)(2), are undisputed on this record, and when construed—as they must be--in the light most favorable to Plaintiff, add up to an open acknowledgment by Dr. Sandifer that he had negligently triggered Lisa's stroke during his manipulations.

Further, as to the informed consent claim, Dr. Sandifer's own consent form supplies sufficient evidence of the "materiality" of the risk of stroke, and Lisa's declaration that no one went over the form with her serves to "rebut" the statutory presumption raised by her signature thereon.

Standard of Review

This being an appeal from Summary Judgment, review is de novo. Michak v. Transnation Title Ins. Co., 148 Wash.2d 788, 794-95, 64 P.3d 22 (2003).

It is well established that, when considering summary judgment, the Court must consider the evidence and inferences in the light most favorable to the non-moving party. Rollins v. Bombardier Recreational Products, 19`1 Wn. App. 876, 366 P.3 33 (2015).

Defendant's Statements to Plaintiff as "Admissions"

ER 801 (d)(2) provides, among other things, that a statement is not "hearsay" if:

* * *

> (2) Admission by Party-Opponent. The statement is offered against a party and is (i) the party's own statement, in either an individual or a representative capacity....(emphasis added)

Could there be better example of "admissions" under this Rule, than one party's statements directly to the other party?

Importantly, admissions in the form of **opinions** are admissible. Young v. Group Health Co-Op of Puget Sound, 85 Wn.2d 332, 337, 534 P.2d 1349 (1975), where the Court said:

> The opinion rule was intended to facilitate more definite answers from witnesses on the stand. 'In its modern form it is a rule of preference for the more concrete answers, if the witness can give them, rather than a rule of exclusion.' E. Clearly, McCormick's Handbook of the Law of Evidence, section 264, at 632 (2d ed. 1972). We must not lost sight of the fact that admissions are made out of court without thought to the specific form in which the statement is made.' Accordingly, the prevailing view is that admissions in the form of opinions are competent.'

See also Lockwood v. AD and S, Inc., 109 Wn.2d 235, 744 P.2d 605 (1987)(in asbestos litigation, opinions in documents generated by defendant's "speaking agents" were admissible); Pannell v. Food Services of America, 61 Wn. App. 418, 810 P.2d (1991) (in wrongful termination litigation, defendant's employees' opinions as to the reasons for plaintiff's termination admissible).

It has been said that the rule excluding a party's statements from the hearsay rule is based not on their inherent trustworthiness, but on our

adversary system. Tribe, Triangulating Hearsay, 87 HARV. L. REV. 957, 961-63(1974). Generally (and certainly in this case), a party can take the stand at trial, to explain away his/her out-of-court "admissions", and the witness testifying to such out of court statements can certainly be cross examined. Therefore, the adversary system supplies "sufficient substitutes for contemporaneous cross examination to 'satisfy' the reasons underlying the hearsay rule". 3A J. WIGMORE, EVIDENCE § 1048 (Chadbourn rev. 1970).

Here, Lisa Barton's report of Dr. Sandifer's admissions to her stands undisputed, unexplained, and, frankly, unaddressed.

Defendant admitted that his treatment caused the stroke

What if the Defendant took the stand at trial and "very specifically admitted" that his treatment had caused Lisa's stroke? How would such evidence, standing alone if necessary, not be sufficient to support a finding of causation?

Here, there is more.

First: Dr. Sandifer's own consent form documents the risk of "stroke" from chiropractic manipulations.

Second: The Emergency Department note from July 24th, 2014[i], the day of Lisa's stroke, reports:

> "The patient comes in complaining of severe vertigo, neck pain and headache. Of note, the patient underwent chiropractic manipulation of her neck this past Monday. She had a similar appointment the week before." (emphasis added)

Third: Lisa's treating neurologist's notes repeatedly document his impression that she had suffered "recent small multifocal bilateral cerebellar strokes---cryptogenic, **although right vertebral dissection is still possible (she had chiropractic maneuvers prior to the onset of her symptoms)**".[ii]

In other words, Dr. Sandifer's "very specific" admission that his treatment caused Lisa's stroke is perfectly consistent with (1) the reality that chiropractic manipulation of the neck can cause stroke; and (2) the medical records generated in Lisa's case.

The leading case on proximate cause is Douglas v. Freeman, 117 Wn.2d 242, 255, 814 P.2d 1160 (1991), in which our Supreme Court said:

> "It is not always necessary, however, to prove every element of causation by medical testimony. If, from the facts and circumstances and the medical testimony given, a reasonable person can infer that the causal connection exists, the evidence is sufficient".

Here, the undisputed "facts and circumstances" are that (1) stroke is a risk of chiropractic manipulation; (2) Lisa's treating neurologist's records reflect the "possibility" of Dr. Sandifer's chiropractic care as the source of her stroke; and (3) Dr. Sandifer "very specifically admitted" to Lisa that his care caused the stroke. A reasonable person could infer causation.

Defendant admitted that his care was negligent

To support a claim for medical negligence, RCW 7.7.0.040 requires proof that the defendant health care provider "failed to exercise that degree of care, skill and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he or she belongs, in the State of Washington, acting in the same or similar circumstances."

No case holds that proof of medical negligence must come in the form of "magic words", or some "script". On the contrary, in White v. Kent Medical Center, Inc., P.S., 61 Wn. App. 163, 172, 810 P.2d 4 (1991), Division I held that "To require experts to testify in a particular format would elevate form over substance."

A few months after the accident (having had abundant time to reflect), Dr. Sandifer forthrightly accepted blame for the stroke, directly to Lisa:

> "In January of 2015, I had another conversation with Dr. Sandifer. I told him of how drastically the stroke had impacted my life, and he apologized profusely. He told me that he had "not been able to sleep for a month" after my stroke because he was **so upset at having caused it**. He told me that nothing like this had ever happened to him in his career, or to his father in his own chiropractic career.
>
> During this conversation, I very specifically told Dr. Sandifer that I would like some sort of acknowledgment from him that this treatment had caused my stroke. Dr. Sandifer very specifically agreed that his treatment had caused my stroke. He told me that 'this exact situation' is why he carries insurance, and that he would contact his insurance company as soon as possible." (Emphasis in original)

Precisely because they are such compelling admissions of fault,

Washington is one of several states that exclude health care providers' apologies, at least under certain circumstances. RCW 5.64.010 excludes evidence of apologies by health care providers, but only if they occur within 30 days of the event in question. Dr. Sandifer's "profuse" apology came almost six months after the event, and is therefore admissible. The obvious inference, and certainly a reasonable inference, is that he apologized because he knew his care had been substandard. And of note: Dr. Sandifer submitted no Declaration purporting to "explain" this apology, or controvert Lisa's testimony.

Finally, Dr. Sandifer told Lisa that "this exact situation" is why he carries insurance, and promised to turn the matter over to his insurance carrier "as soon as possible". While under ER 411 the fact that Dr. Sandifer carries insurance is not admissible on the issue of fault, the Rule allows such evidence for "another purpose". Here, the "other purpose" would be Dr. Sandifer's state of mind, i.e., his full knowledge and acceptance that he had negligently injured Lisa.

To be sure, a Defendant could acknowledge a possible claim and provide insurance information, without such being construed as an acknowledgment of fault. But consider the extent of Dr. Sandifer's statements:

> He "apologized profusely" for having caused Lisa's stroke;
>
> He had "not been able to sleep for a month", being "so upset at having caused" it;

He "very specifically agreed" that his treatment had caused the stroke;

He assured Lisa that "this exact situation" is why he carries insurance; and

He assured her that he would contact his insurance company "as soon as possible".

Why wouldn't a reasonable jury conclude that the combination of these undisputed statements was, and was intended to be a frank admission of negligence? Surely, Plaintiff was entitled to this inference on the Summary Judgement Calendar.

Defendant's own consent form establishes the materiality of the risk of stroke

The Motion for Summary Judgment asserted that Lisa had "failed to produce medical expert testimony in support of her informed consent claims". Ironically enough, Dr. Sandifer's own consent form specifically describes "stroke" as a risk of his care! Again, this is an obvious "admission" under ER 801 (2), as a statement of which Dr. Sandifer "has manifested an adoption or belief in its truth."

That being as it may, to prove the failure of a health care provider to obtain informed consent to his/her treatment, RCW 7.70.050 requires sufficient evidence that:

That the health care provider failed to inform the patient of a "material fact";

That the patient consented to the treatment without being aware of or fully informed of the "material fact";

That a reasonably prudent patient under similar circumstances would not have consented to the treatment, if informed of the "material fact";

The treatment in question proximately caused injury to the patient.

Proof of the "materiality" of a risk requires "some" expert testimony, as to the "scientific nature" of the risk. Once this is done, the trier of fact determines whether a reasonably prudent patient would assign significance to it, without need of expert testimony.

No case has announced a precise formula for determining whether there has been sufficient evidence of the "scientific nature" of the risk. However, in Adams V. Richland Clinic, Inc., P.S., 37 Wn. App. 650, 660, 681 P.2d 1305 (1984), testimony that the "risk" in question was "not significant" was held to be sufficient to support a finding of materiality by the jury:

> Dr. Lennard testified Mrs. Adams' ulcer and hernia were the result of her surgeries, but opined that the risk of an ulcer was not "significant". This is sufficient expert testimony on the materiality question with respect to these risks to get it to the jury. The finder of fact could consider Dr. Kennard's opinion on "significance" in deciding whether the reasonably patient would attach significance, but would not be bound."

Here, Dr. Sandifer's own consent form specifically lists "stroke" as a risk of chiropractic care, albeit "extremely rare". A jury could decide that a reasonably prudent patient would attach significance to a risk listed in the consent form. Indeed, the inarguable prupose of the Form is to document the patient's awareness of "risks" that Dr. Sandifer felt she should be aware of.

RCW 7.70.060 creates a rebuttable assumption that the patient gave informed consent, where the patient has signed a consent form. The presumption is rebutted by a preponderance of the evidence. RCW 7.70.060 (1).

Here, a jury could find that the presumption was rebutted, based on Lisa's undisputed testimony that she has no memory of signing the form, and that no one went over it with her, and her testimony that if she had been made aware of the risks described in the consent form, she would not have gone through with the treatment! Remember, she decided to see Dr. Sandifer in the first place for "minor" and "occasional" neck and back pain.

CONCLUSION

Plaintiff asks the Court to reverse and remand for trial.

DATED this 22 day of December, 2016.

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Attorney for Plaintiff

[I] This record was submitted by the Defendant with his Motion. Exhibit 7 to Daylong Declaration, (CP 13-49).
[II] This Note was likewise submitted with Defendant's Motion Exhibit 9 to Daylong Declaration. (CP 13-49.)

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The undersigned declares under penalty of perjury, under the laws of the State of Washington, that the following is true and correct: That on December 22, 2016, I arranged for service VIA ELECTRONIC MAIL and US MAIL of the foregoing APPELLANT'S BRIEF to the parties to this action as follows:

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